Advanced Allergy & Asthma Care

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Advanced Allergy & Asthma Care, PLLC

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NEW PATIENT QUESTIONNAIRE: *REMEMBER TO SIGN AT BOTTOM OF PAGE 2!!!*

Patient Name: _____ Date of Birth: _____Age_____ Sex_____
Referred By: _____ Primary Doctor: _____

1. Briefly describe the reason for your visit and what you hope to accomplish:_____

_____

2. SYMPTOMS:

Nose:	Runny nose	Sneezing	Itching	Stuffy nose	Sniffing
	Nosebleeds	Mouth Breathing	Snoring	Loss of smell or taste	
Throat:	Postnasal drip	Sore throats	Throat clearing	Hoarseness	Itching
Sinus:	Headaches	Bad breath	Sinus infections	Frequent colds	Pressure
Ear:	Fullness	Pain	Itching	Hearing loss	Ear Infections
Eyes:	Redness	Itching	Watering	Puffiness	Discharge
Skin:	Rash	Hives	Eczema	Itching	Dryness
Chest:	Coughing	Wheezing	Tightness	Shortness of Breath	Bronchitis

Other:_____
How long have you had these symptoms?_____
Have you missed any time from work/school because of your allergies? Yes / No If so, how many days in the last 12 months?_____

3. SYMPTOMS AFFECTED BY:

Location: Indoor Outdoor Home Office Vacation
Time of Day: Morning Afternoon Evening Night All the Time
Seasons: Spring Summer Fall Winter All Year
Weather: Hot Cold Dry Humid Change in Weather
Allergens: House dust Cat dander Dog dander Pollen Cut grass Mold/Mildew
Irritants: Perfumes Cleaners Cigarette Smoke Paint Cooking Chemical odors
Other factors: Exercise Medication Insect Sting Foods / Food Additives Cosmetics Laughing Stress Infections Menstrual Cycle

4. What MEDICATIONS have you tried for this condition? (circle all that apply)

Prescription nose sprays: Nasonex, Qnasl, Astelin(azelastine), Dymista, Astepro, Atrovent(ipratropium bromide).
OTC Nose sprays: Flonase(fluticasone), Rhinocort, Nasacort, Cromolyn, Afrin (oxymetazoline), Nasal saline.
Antihistamines: Claritin (loratadine), Zyrtec (cetirizine), Allegra (fexofenadine), Benadryl (diphenhydramine), Atarax (hydroxyzine).
Quick relief inhalers: Albuterol, ProAir, Ventolin, Proventil, Xopenex, Albuterol nebulized solution.
Daily Asthma inhalers: Flovent 44 /110/ 220 mcg, Pulmicort 90/180 mcg, Qvar 40/80 mcg, Asmanex 110/220 mcg, Alvesco 80/160mcg, Wixela/Advair 100/250/500, Symbicort 80/160mcg, Dulera 100/200 mcg, Breo 100/200, Trelegy 100/200, Breztri, Spiriva 1.25/2.5, Incruse Ellipta. Have you ever been prescribed oral steroids (Prednisone, Prednisolone, Medrol)?
If YES, when and why?_____
Which of the above circled meds helped? If they did not help or could not tolerate, place an "X" through the med.

_____

5. MEDICAL HISTORY: (list all medical problems)

Hospitalizations/ER and Surgeries:

_____
_____
_____
Besides your primary care physician, what other doctors do you routinely see (list name, specialty and ph #)?
_____

6. CURRENT MEDICATIONS:

You may attach a list if you have one. Do not forget to list ALL OTC, topicals, eye drops, etc!

_____
_____

If you have ECZEMA, what Soap_____Cream/Lotion_____Topical steroids: mometasone, triamcinolone, fluocinolone oil, clobetasol, hydrocortisone, desonide, westcort, beclomethasone, fluocinonide, other_____

7. SOCIAL HISTORY:

Do you have **exposure** to PETS? **Circle: DOG / CAT / BIRD** _____ INDOOR / OUTDOOR For how long_____
Where were you born?_____Raised?_____When did you move to Florida?_____
Have you ever smoked? Yes /No If yes, how many years?_____ Still smoke?_____Quit?_____
Do any household members smoke?_____If so,specify_____

8. SOCIAL HISTORY: (THIS SECTION ONLY FOR ADULTS)

Are you married_____single_____divorced_____How many children do you have?_____
Their ages:_____ Do you drink alcohol? Yes /No
How often:_____Do you use any illicit drugs? Yes /No If yes, specify_____

EMPLOYMENT HISTORY: What is your occupation?_____Current Employer?_____Since_____
Are you exposed to chemicals or smoking at work?_____Are your symptoms worse at work? Yes / No
If yes, specify_____

9. FAMILY HISTORY:

Do any direct family members (siblings, parents, grandparents, children) have a history of allergy? If yes, list relatives and their ages:
Asthma_____
Allergicrhinitis_____
Eczema_____
Food Allergies _____
Autoimmune Disease_____ImmuneDeficiency_____Angioedema_____Mastocytosis_____
Anaphylaxis_____

10. BIRTH HISTORY: (THIS SECTION ONLY FOR CHILDREN <18 years old):

Born Full Term / Pre–Term? How many weeks Pre –Term?_____ Complications at birth?_____
Breast Fed?_____

Immunizations Up To Date? Y / N Development Normal? Y / N Growth Normal? Y / N Daycare? Y / N _____

11. ENVIRONMENTAL HISTORY:

Do you live in a / an: House_____Apartment_____Condo_____Mobile home_____
Is it located on near: The water_____ Age of house: _____ How long have you been living there?_____
Is there any mildew?_____cockroaches?_____ Type of Air conditioning: Central, Window, etc._____
Type of filters: Regular, HEPA, etc._____ Type of flooring: (carpet, wood, tile, vinyl, etc.)_____
Age of carpet?_____ Is carpet throughout_____ In bed rooms_____in living room_____
How old is your mattress?_____ Is your mattress: foam_____encased in plastic_____ waterbed_____
other_____
How old is your pillow? _____Is your pillow: feather____encased in plastic____synthetic (Dacron)_____
foam_____other_____

12. ALLERGIC HISTORY: Are there any foods that you cannot eat for any reason except for taste? If so, which and Why?
_____
Are there any medications that you cannot tolerate?_____
If so, Which and Why?_____
Have you ever had a reaction to X-ray dye?_____Have you ever had a reaction to latex products (i.e. glove, balloon, etc)?_____
Have you ever had a serious allergic reaction (shortness of breath, wheezing, hives, dizziness and fainting etc.) after an insect sting? (wasp, honey bee, yellow jacket, fire ant, etc.). If so, please specify_____

PREVIOUS ALLERGY EVALUATION AND TREATMENT:

Have you ever had allergy skin testing?** Yes / No If Yes, date: _____ Physician's Name:_____
What did the skin testing show?_____
Have you ever received allergy injections? Yes/ No
If yes, dates:_____Did your symptoms improve with allergy injections? Yes / No
Have you ever had an adverse reaction to an allergy injection? Yes/No_____
**NOTE if you have had allergy skin testing previously, your insurance may not cover it again, subject to your benefits.

_____	_____	_____
Signature of Patient/Parent/Guardian	Name of Patient/Parent/Guardian (PRINT)	Date